

APPENDIX

Township Check (Township Form No. 6)

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Township Trustees Quarterly Poor Relief Report of Actual and Estimated
Receipts and Disbursements (Township P.R. Form 8)

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Official Receipt - Marion County Small Claims Court (Township Form No. 79M)

Check, Marion County Small Claims Court (Township Form No. 83M)

Trust Check, Marion County Small Claims Court (Township Form No. 84M)

HOURS WORKED	GROSS PAY	FEDERAL W/TAX	SOCIAL SEC.	STATE W/TAX	INSUR- ANCE				NET PAY	PERIOD ENDING	EMPLOYEE DETACH AND RETAIN

PRESCRIBED BY STATE
BOARD OF ACCOUNTS

TWP. FORM NO. 6 (REV. 1967)

This Warrant Void Two (2) Years
After Dec. 31 of the Year of Issue.

SAMPLE

Approp. No. _____ \$ _____
Approp. No. _____ \$ _____
Approp. No. _____ \$ _____

Pay to the _____ Fund _____ , ____
Order of _____ \$ _____

_____ Dollars
100

For _____

TRUSTEE OF ABOVE-NAMED TOWNSHIP

HOURS WORKED	GROSS PAY	FEDERAL W/TAX	SOCIAL SEC.	STATE W/TAX	INSUR- ANCE				NET PAY	PERIOD ENDING	COUNTY AUDITOR'S COPY

PRESCRIBED BY STATE
BOARD OF ACCOUNTS

TWP. FORM NO. 6 (REV. 1967)

SAMPLE

Approp. No. _____ \$ _____
Approp. No. _____ \$ _____
Approp. No. _____ \$ _____

_____ Fund _____ , ____
Paid To: _____ \$ _____

_____ Dollars
100

For _____

I certify this to be the exact sum received and that it is for the purpose herein
stated; that no part of said sum has been retained by, returned to, or has been
directly or indirectly agreed to be returned to, the Trustee or any other person.

VOUCHER - to accompany the Annual Report and be filed with County Auditor after close of year.

Signed: _____
PAYEE

HOURS WORKED	GROSS PAY	FEDERAL W/TAX	SOCIAL SEC.	STATE W/TAX	INSUR- ANCE				NET PAY	PERIOD ENDING	OFFICE COPY

PRESCRIBED BY STATE
BOARD OF ACCOUNTS

TWP. FORM NO. 6 (REV. 1967)

SAMPLE

Approp. No. _____ \$ _____
Approp. No. _____ \$ _____
Approp. No. _____ \$ _____

_____ Fund _____ , ____
Paid To: _____ \$ _____

_____ Dollars
100

For _____

Posted To Financial and Appropriation Record _____

NON - NEGOTIABLE

Prescribed by State Board of Accounts

RECORD OF LEASE CONTRACTS AND

NOTE: Use General Form No. 53 for Record of Bonded Indebtedness

	Nature of Instrument 1	Date of Issue 2	To Whom Payable 3	Purpose of Issue 4	
1					
2					

(Columnar Headings for Left Hand Side of Sheet)

Township Form No. 14 (Rev. 1955) - Ruling C

INDEBTEDNESS OTHER THAN BONDS

	Rate of In- terest 5	Due Date of Final Payment 6	Total Amount Payable 7	PAYMENTS ON PRINCIPAL			INTEREST PAYMENTS		
				Date 8	Amount 9	Balance Due 10	Date 11	Amount 12	
1									1
2									2

(Columnar Headings for Right Hand Side of Sheet)

Prescribed by State Board of Accounts

TOWNSHIP TRUSTEE'S

	Policy Number 1	Name of Insurance Company 2	Property Covered 3	Kind of Insurance (show % of coinsur- ance, if any) 4	Date of Policy 5	
1		Premiums Payable by Years Brought Forward				
2						

(Columnar Headings for Left Hand Side of Sheet)

Township Form No. 14 (Rev. 1955) - Ruling B

INSURANCE RECORD

	Expiration Date of Policy 6	Amount of Insurance 7	Total Premium Payable 8	PREMIUMS PAYABLE BY YEARS					
				9	10	11	12	13	
1									1
2									2

(Columnar Headings for Right Hand Side of Sheet)

Note: The last line of this form is to be ruled for totals in columns 9, 10, 11, 12 and 13, and the words "Premiums Payable by Years Carried Forward" is to be printed on this last line.

RECEIPT

Office of Township Trustee

NO. _____

IN _____

Payment Type and Amount					
Cash Amount	Check/Draft Amount	MO Amount	Credit Card/ Bank Card Amount	EFT Amount	Other

RECEIVED FROM _____ \$ _____

THE SUM OF _____ DOLLARS

ON ACCOUNT OF _____ 100

SAMPLE

Township Trustee

(Original)

NO. _____

Date
Issued

issued
To

Payment Type and Amount					
Cash Amount	Check/Draft Amount	MO Amount	Credit Card/ Bank Card Amount	EFT Amount	Other

ON ACCOUNT OF _____

Township TrusteeAmount of
Receipt

SAMPLE

(Duplicate)

**RESOLUTION
ESTABLISHING SALARIES OF TOWNSHIP OFFICERS AND EMPLOYEES**

BE IT RESOLVED by the Township Board of _____ Township
 _____ County, Indiana

That pursuant to IC 36-6-6-10(b), the salaries stated below are fixed for the officers and employees of the township for the year _____.

POSITION OF OFFICE	Number of Positions	Rate of Compensation	Per *
Township Trustee Township Duties			
(1) Assessing Duties (not county portion)			
Total for Township Trustee			
Township Clerk			
Members of the Township Board			
Fire Department Personnel			
Poor Relief Personnel			
Supervisors of Investigators			
Investigators			
Supervisors of Other Assistants			
Other Assistants			
Other Employees (Detail)			

ADOPTED this _____ day of _____, _____.

Attest: _____
 Township Trustee Members of the Township Board

* Show: per year, per month, per day, etc.

Include in this resolution ALL officers and employees of the township, except elected Township Assessors and deputies and employees of elected Township Assessors.

(1) IC 36-6-6-10(e) states "In a township that does not elect a township assessor under IC 36-6-5-1, the township legislative body may appropriate available township funds to supplement the salaries of elected or appointed officers to compensate them for performing assessing duties. However, in any calendar year no officer or employee may receive a salary and additional salary supplements which exceed the salary fixed for that officer or employee under subsection (b)."

Prescribed by State Board of Accounts

Expires One Year
From Date of Issue

(Date Issued) _____

DOG TAX/KENNEL LICENSE RECEIPT

_____ TOWNSHIP
_____ COUNTY, INDIANA

Township Form No. 18 (1997)

NO. _____

RECEIVED OF _____

STREET/R.R. NO. _____ CITY/TOWN _____ ZIP _____

THE SUM OF _____ DOLLARS

IN FULL PAYMENT OF DOG TAX/KENNEL LICENSE FOR ONE YEAR FROM DATE OF ISSUE

Payment Type and Amount					
Cash Amount	Check/Draft Amount	MO Amount	Credit Card/Bank Card Amount	EFT Amount	Other

No.	Breed	Sex	Age	Tag No.	Fee
	Neutered Dogs				
	Nonneutered Dogs				
	Each Additional Dog				
	Major Kennel License (15 or More Dogs)				
	Minor Kennel License (Less Than 15 Dogs)				
Total Amount Due					

KENNEL LICENSE

The above-named is hereby licensed to conduct a _____ dog kennel if _____ Major or Minor the kennel license fee has been paid.

Signed: _____ Trustee/Assessor

Prescribed by State Board of Accounts

Expires One Year
From Date of Issue

(Date Issued) _____

DOG TAX/KENNEL LICENSE RECEIPT

_____ TOWNSHIP
_____ COUNTY, INDIANA

Township Form No. 18 (1997)

NO. _____

RECEIVED OF _____

STREET/R.R. NO. _____ CITY/TOWN _____ ZIP _____

THE SUM OF _____ DOLLARS

IN FULL PAYMENT OF DOG TAX/KENNEL LICENSE FOR ONE YEAR FROM DATE OF ISSUE

Payment Type and Amount					
Cash Amount	Check/Draft Amount	MO Amount	Credit Card/Bank Card Amount	EFT Amount	Other

No.	Breed	Sex	Age	Tag No.	Fee
	Neutered Dogs				
	Nonneutered Dogs				
	Each Additional Dog				
	Major Kennel License (15 or More Dogs)				
	Minor Kennel License (Less Than 15 Dogs)				
Total Amount Due					

KENNEL LICENSE

The above-named is hereby licensed to conduct a _____ dog kennel if _____ Major or Minor the kennel license fee has been paid.

Signed: _____ Trustee/Assessor

Prescribed by State Board of Accounts

Expires One Year
From Date of Issue

(Date Issued) _____

DOG TAX/KENNEL LICENSE RECEIPT

_____ TOWNSHIP
_____ COUNTY, INDIANA

Township Form No. 18 (1997)

NO. _____

RECEIVED OF _____

STREET/R.R. NO. _____ CITY/TOWN _____ ZIP _____

THE SUM OF _____ DOLLARS

IN FULL PAYMENT OF DOG TAX/KENNEL LICENSE FOR ONE YEAR FROM DATE OF ISSUE

Payment Type and Amount					
Cash Amount	Check/Draft Amount	MO Amount	Credit Card/Bank Card Amount	EFT Amount	Other

No.	Breed	Sex	Age	Tag No.	Fee
	Neutered Dogs				
	Nonneutered Dogs				
	Each Additional Dog				
	Major Kennel License (15 or More Dogs)				
	Minor Kennel License (Less Than 15 Dogs)				
Total Amount Due					

KENNEL LICENSE

The above-named is hereby licensed to conduct a _____ dog kennel if _____ Major or Minor the kennel license fee has been paid.

Signed: _____ Trustee/Assessor

Office of the Trustee

of _____ Township, _____ County

NOTICE OF UNPAID DOG TAX

Name _____

Address _____

SAMPLE

You are hereby notified that the assessment records of this township show that the state dog tax (license fee) for the year ____ has not been paid on a dog or dogs described as follows:

Neutered _____ Color _____ Breed _____

Nonneutered _____ Color _____ Breed _____

Each Additional _____ Color _____ Breed _____

If payment is made to the township trustee within 10 days of this notice the total amount due will be

\$ _____

Date of Notice _____

Trustee _____ Township

_____ County

(Over)

This notice is served pursuant to Public Laws 192 and 193 of Acts of 1987 and provides in part:

"Each township trustee shall perform the duties imposed by this chapter. If a dog owner has failed to turn in a dog for taxation purposes, the trustee shall notify the owner that the trustee is listing the unpaid taxes within a period of ten (10) days, at which time the person will be assessed double the amount of taxes provided by this chapter unless the person owning the dog appears voluntarily within the ten (10) days and:

- (1) proves to the satisfaction of the trustee that the person owned no such dog at the time the census was made; or
- (2) makes an affidavit to be kept on file by the trustee to the effect that the failure to report a dog for taxation was not intentional and was not purposely omitted for the purpose of avoiding payment of taxes."

Application for Township Assistance

PHONE NUMBER () -	APPLICATION DATE / /	APPLICATION TIME : <input type="checkbox"/> AM <input type="checkbox"/> PM	CASE NUMBER
AREA ### ####	MM DD YY	HH MM (total:)	office use only

Applicant's Full Name**Social Security #****Date of Birth**

<input type="checkbox"/> male <input type="checkbox"/> female			— —	/ /
LAST	FIRST	MI	optional	MM DD YY

Other Adult's Full Name**Social Security #****Date of Birth**

<input type="checkbox"/> male <input type="checkbox"/> female			— —	/ /
LAST	FIRST	MI	optional	MM DD YY

Other Adult's Full Name**Social Security #****Date of Birth**

<input type="checkbox"/> male <input type="checkbox"/> female			— —	/ /
LAST	FIRST	MI	optional	MM DD YY

Current Address

				____ Months ____ Years
Street Address / P.O. Box	Apt. #	City, State	Zip	How Long

Previous Address

				____ Months ____ Years
Street Address / P.O. Box	Apt. #	City, State	Zip	How Long

QUESTION	APPLICANT	OTHER ADULT	OTHER ADULT
What is your housing status?	<input type="checkbox"/> Own <input type="checkbox"/> Buying <input type="checkbox"/> Renting <input type="checkbox"/> Homeless <input type="checkbox"/> Other	<input type="checkbox"/> Own <input type="checkbox"/> Buying <input type="checkbox"/> Renting <input type="checkbox"/> Homeless <input type="checkbox"/> Other	<input type="checkbox"/> Own <input type="checkbox"/> Buying <input type="checkbox"/> Renting <input type="checkbox"/> Homeless <input type="checkbox"/> Other
What is your marital status?	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed

This office does not discriminate on the basis of race, color, national origin, sex religion, age or handicap status. Anyone needing special aid, readers, or interpreters, please notify us in advance at least 48 hours.

In the following table, list ALL persons living within this household. For EACH person check ☒ the relationship to the applicant and circle ALL income sources for that person. Signature, affirming income, required of all household members eighteen (18) and older. *Note: Social Sec. #'s are optional.*

Person's Name	Relationship		Income Source	Amount (monthly)
_____ Print _____ Signature	<input type="checkbox"/> Yourself	<div style="border: 1px solid black; padding: 2px; text-align: center;">/ /</div> Date of Birth <div style="border: 1px solid black; padding: 2px; text-align: center;">— —</div> Social Sec. # (optional)	No Income Social Security Unemployment Veteran's Insurance Strike Benefits Wages AFDC Pension Support Gifts Other	
_____ Print _____ Signature	<input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Relative <input type="checkbox"/> Room Mate <input type="checkbox"/> Other Adult	<div style="border: 1px solid black; padding: 2px; text-align: center;">/ /</div> Date of Birth <div style="border: 1px solid black; padding: 2px; text-align: center;">— —</div> Social Sec. # (optional)	No Income Social Security Unemployment Veteran's Insurance Strike Benefits Wages AFDC Pension Support Gifts Other	
_____ Print _____ Signature	<input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Relative <input type="checkbox"/> Room Mate <input type="checkbox"/> Other Adult	<div style="border: 1px solid black; padding: 2px; text-align: center;">/ /</div> Date of Birth <div style="border: 1px solid black; padding: 2px; text-align: center;">— —</div> Social Sec. # (optional)	No Income Social Security Unemployment Veteran's Insurance Strike Benefits Wages AFDC Pension Support Gifts Other	
_____ Print _____ Signature	<input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Relative <input type="checkbox"/> Room Mate <input type="checkbox"/> Other Adult	<div style="border: 1px solid black; padding: 2px; text-align: center;">/ /</div> Date of Birth <div style="border: 1px solid black; padding: 2px; text-align: center;">— —</div> Social Sec. # (optional)	No Income Social Security Unemployment Veteran's Insurance Strike Benefits Wages AFDC Pension Support Gifts Other	
_____ Print _____ Signature	<input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Relative <input type="checkbox"/> Room Mate <input type="checkbox"/> Other Adult	<div style="border: 1px solid black; padding: 2px; text-align: center;">/ /</div> Date of Birth <div style="border: 1px solid black; padding: 2px; text-align: center;">— —</div> Social Sec. # (optional)	No Income Social Security Unemployment Veteran's Insurance Strike Benefits Wages AFDC Pension Support Gifts Other	
_____ Print _____ Signature	<input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Relative <input type="checkbox"/> Room Mate <input type="checkbox"/> Other Adult	<div style="border: 1px solid black; padding: 2px; text-align: center;">/ /</div> Date of Birth <div style="border: 1px solid black; padding: 2px; text-align: center;">— —</div> Social Sec. # (optional)	No Income Social Security Unemployment Veteran's Insurance Strike Benefits Wages AFDC Pension Support Gifts Other	
_____ Print _____ Signature	<input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Relative <input type="checkbox"/> Room Mate <input type="checkbox"/> Other Adult	<div style="border: 1px solid black; padding: 2px; text-align: center;">/ /</div> Date of Birth <div style="border: 1px solid black; padding: 2px; text-align: center;">— —</div> Social Sec. # (optional)	No Income Social Security Unemployment Veteran's Insurance Strike Benefits Wages AFDC Pension Support Gifts Other	

Total adults in the household: _____ Total children in the household: _____
 Total of ALL persons living in the household: _____
 Total GROSS income received in the household last 30 days: \$ _____

Does anyone live in this household temporarily or occasionally? YES NO

If YES, who and how often: _____

List all motorized vehicles owned by ANY person in this household:

Type: _____ (Car/Truck/Boat/Motorcycle) Year: _____ Make: _____
 Type: _____ (Car/Truck/Boat/Motorcycle) Year: _____ Make: _____
 Type: _____ (Car/Truck/Boat/Motorcycle) Year: _____ Make: _____

QUESTION	APPLICANT	OTHER ADULT	OTHER ADULT
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What is your income status?

name: _____
☐ Wages Stopped
☐ Waiting on Income
☐ Receiving Income
☐ No Income

name: _____
☐ Wages Stopped
☐ Waiting on Income
☐ Receiving Income
☐ No Income

☐ Wages Stopped
☐ Waiting on Income
☐ Receiving Income
☐ No Income

What is your employment status?

☐ Currently working
☐ Laid off on: _____
☐ Never worked
☐ Quit: *
☐ Fired: *
☐ Sick Leave
☐ Maternity Leave
☐ On strike
☐ Trying to find work

☐ Currently working
☐ Laid off on: _____
☐ Never worked
☐ Quit: *
☐ Fired: *
☐ Sick Leave
☐ Maternity Leave
☐ On strike
☐ Trying to find work

☐ Currently working
☐ Laid off on: _____
☐ Never worked
☐ Quit: *
☐ Fired: *
☐ Sick Leave
☐ Maternity Leave
☐ On strike
☐ Trying to find work

* answers require explanation below

*

Other Financial Information

	Applicant		Other Adult		Other Adult	
Do you have life insurance?	Yes	No	Yes	No	Yes	No
Do you have another type of insurance?	Yes	No	Yes	No	Yes	No
Do you have any investment holdings? (Stocks, Bonds, CD's, IRA's)	Yes	No	Yes	No	Yes	No
Do you have any cash on hand?	Yes	No	Yes	No	Yes	No
If YES, give amount	\$ _____		\$ _____		\$ _____	
Do you have a checking account?	Yes	No	Yes	No	Yes	No
Do you have a savings account?	Yes	No	Yes	No	Yes	No
If YES, give name of each bank & current balance						
Does anyone in the household have any claims, including lawsuits, against a person, insurance company, employer, or government agency from which you (they) expect to receive a recovery (money)?	YES NO		YES NO		YES NO	
If yes, explain:	_____					

PROPERTY OWNERSHIP

	Applicant	Other Adult	Other Adult
	YES NO	YES NO	YES NO
Do you own any property?			
If YES, show address:	_____		
Show name of mortgage company:	_____		
Shown amount of mortgage payment:	_____		
Show number of years owned:	_____	Approximate market value of home: _____	

RENTAL HISTORY

Number of adults on the lease: _____ Co-lessee's name (if any): _____

Show name of apartment complex or landlord: _____

Address of complex or landlord: _____

Phone number of complex or landlord: _____

What date did you move into this rental unit: _____ Monthly rent amount: _____

Is anyone in the household related to the landlord? YES NO If yes, state relationship: _____

Are any utilities included? YES NO If yes, which ones?: _____

EMPLOYMENT HISTORY

Applicant	Other Adult name: _____	Other Adult name: _____
Your most recent employer: _____		
Date you started work there: _____		
Date you last worked there: _____		
Reason not working now: _____		
2nd most recent employer: _____		
Date you started work there: _____		
Date you last worked there: _____		
Reason not working now: _____		

MILITARY SERVICE

	Applicant	Other Adult	Other Adult
Serial Number:			
Enlistment Date:			
Branch of Service:			
Discharge Date:			

CITIZENSHIP

Is everyone in the household a U.S. citizen? YES NO

If no, please explain status by which you are in the U.S.: _____

Applicant's Maiden Name (if married): _____
Household members' relatives (parents, brothers, sisters, grandparents, aunts, uncles) including "step" relatives: _____

How have they helped?
Are they willing to help?

SAMPLE

If there are minor children in the home, is child support ordered for them by a court?	YES	NO
If not will you go to court to get support?	YES	NO

Are you receiving child support? YES NO If YES, how much ? _____
Name & address of child(ren)'s other parent if not in household: _____

Have you or someone in the household been helped from any other source such as churches, multi-service centers, or friends whom you have not already listed on this form? YES NO

If YES, who, how much & when? _____

Amount of debt	Date Purchased	Name of Creditor	Items Purchased	Value	Amt. Paid	Last Pay Date
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EXPENSE INFORMATION

List below any payments made by any household member to any source in the last thirty (30) days:

Amount	Paid to	Date Paid	Amount	Paid to	Date Paid

SAMPLE

What do you owe today on your rent or mortgage? \$ _____

What do you owe today on your utilities? _____

Electricity \$ _____ Gas/Heating \$ _____ Water \$ _____ Cable \$ _____

Telephone \$ _____ Sewer \$ _____ Trash Removal \$ _____ Cable \$ _____

Are any of these bills in someone else's name? YES NO

If YES, which ones and whose name? _____

What is your reason for asking for Trustee help?

- ☐ No Income
☐ Not Enough Income
☐ Income Stolen
☐ Emergency Event

Has there been an emergency or extraordinary circumstance you wish the Trustee to consider in your application? YES NO

If YES, explain: _____

Specifically, what are you asking for help with today?

OTHER PUBLIC ASSISTANCE**Are you receiving or have you applied for the following:****APPLICANT**

Subsidized Sec. 8, HUD, or other public housing:	YES	NO	Date applied: ____________	
Utility Allotment	YES	NO	Date Applied: ____________	Amount: _____
Food Stamps	YES	NO	Date Applied: ____________	Amount: _____
AFDC Welfare	YES	NO	Date Applied: ____________	Amount: _____
Other Trustee Office	YES	NO	Date Applied: ____________	Amount: _____
Social Security (any type)	YES	NO	Date Applied: ____________	Amount: _____
V.A. Benefits (any time)	YES	NO	Date Applied: ____________	Amount: _____
EAP Utility assistance	YES	NO	Date Applied: ____________	Amount: _____
FEMA Funds	YES	NO	Date Applied: ____________	Amount: _____
Unemployment Benefits	YES	NO	Date Applied: ____________	Amount: _____
Grants/Loans	YES	NO	Date Applied: ____________	Amount: _____
Any other type of help	YES	NO	Date Applied: ____________	Amount: _____

OTHER ADULT

Subsidized Sec. 8, HUD, or other public housing:	YES	NO	Date applied: ____________	
Utility Allotment	YES	NO	Date Applied: ____________	Amount: _____
Food Stamps	YES	NO	Date Applied: ____________	Amount: _____
AFDC Welfare	YES	NO	Date Applied: ____________	Amount: _____
Other Trustee Office	YES	NO	Date Applied: ____________	Amount: _____
Social Security (any type)	YES	NO	Date Applied: ____________	Amount: _____
V.A. Benefits (any time)	YES	NO	Date Applied: ____________	Amount: _____
EAP Utility assistance	YES	NO	Date Applied: ____________	Amount: _____
FEMA Funds	YES	NO	Date Applied: ____________	Amount: _____
Unemployment Benefits	YES	NO	Date Applied: ____________	Amount: _____
Grants/Loans	YES	NO	Date Applied: ____________	Amount: _____
Any other type of help	YES	NO	Date Applied: ____________	Amount: _____

OTHER ADULT

Subsidized Sec. 8, HUD, or other public housing:	YES	NO	Date applied: ____________	
Utility Allotment	YES	NO	Date Applied: ____________	Amount: _____
Food Stamps	YES	NO	Date Applied: ____________	Amount: _____
AFDC Welfare	YES	NO	Date Applied: ____________	Amount: _____
Other Trustee Office	YES	NO	Date Applied: ____________	Amount: _____
Social Security (any type)	YES	NO	Date Applied: ____________	Amount: _____
V.A. Benefits (any time)	YES	NO	Date Applied: ____________	Amount: _____
EAP Utility assistance	YES	NO	Date Applied: ____________	Amount: _____
FEMA Funds	YES	NO	Date Applied: ____________	Amount: _____
Unemployment Benefits	YES	NO	Date Applied: ____________	Amount: _____
Grants/Loans	YES	NO	Date Applied: ____________	Amount: _____
Any other type of help	YES	NO	Date Applied: ____________	Amount: _____

Has anyone in the household been terminated from, refused or had AFDC payments reduced? YES NO

If YES, why? _____

Has anyone in the household ever been convicted of welfare fraud under IC 35-43-5-7? YES NO

If YES, when & where? _____

READ CAREFULLY * NOTICE OF PUBLIC LAW

Indiana Code 12-20-6-9 requires the township trustee to investigate my circumstances, and the cause of my condition. I understand that I am required to cooperate in such investigation. I understand that Indiana Code 12-20-6-8 requires the trustee to notify me of the action taken (approval, denial, pending) on my case within 72 hours (excluding weekends and legal holidays) and that the trustee must retain a copy of each application whether or not relief is granted.

Indiana Code 12-20-16-2 prohibits the Trustee from providing medical assistance if the applicant could qualify for that assistance under the Hospital Care for the indigent Program (IC 12-16). The township may not provide assistance for payment for more than 30 days heating fuel or electric services assistance unless you have applied for assistance from the Division of Disability, Aging, and Rehabilitative Services as stated under IC 12-20-16-3. IC 12-20-6-5 provides that applicants, or a member of the applicant's household, granted emergency poor relief assistance, who may be eligible for other public assistance shall within fifteen (15) working days of the emergency assistance, file an application with the appropriate government agency. If the applicant, or a member of the applicant's household, fails to file within fifteen (15) working days, no further Trustee assistance may be granted for sixty (60) days following the emergency Trustee assistance granted. Applicants for food assistance may not be provided food assistance for more than thirty (30) days unless an application food stamps is filed with the Division of Family and Children. IC 12-20-10-1 provides that if applicants applying for aid are in good health, or if any member of their household are so, the trustee shall require those able to work to seek employment and the trustee shall refuse any aid until the trustee is satisfied that the persons claiming help are endeavoring to find work for themselves. IC 12-20-11-1 requires a recipient or other adult member of the household, with certain exceptions, to do any work needed to be done within the county or an adjoining township in any other county for any governmental unit having jurisdiction in those townships.

I HAVE READ THE ABOVE NOTICE OF PUBLIC LAW._____
Signature of Applicant_____
Signature of Other Adult_____
Signature of Other Adult

Are you willing to work for the township and actively seek employment as a condition of receiving trustee assistance?

APPLICANT: YES NO OTHER ADULT: YES NO OTHER ADULT: YES NO
If no, explain why not: _____

AFFIDAVIT

I certify and affirm under penalties of perjury that the information I have given on this application is true and correct to the best of my knowledge and belief in every respect as to myself and members of my family and household, and that I have not withheld any information on matters bearing upon the eligibility and need for relief from myself and members of my family and household, and that I and the members of my family and household have no other means of support than those stated in this application. I also certify that I have not been convicted under IC 35-43-5-7 (Welfare Fraud) and am eligible to receive poor relief assistance.

Signature of Applicant_____
Signature of Other Adult_____
Signature of Other Adult**NOTE:**

All household members eighteen and older must sign where indicated for application to be complete.

CONSENT TO THE DISCLOSURE OF INFORMATION TO THE TOWNSHIP TRUSTEE

I, _____, Case Number _____, residing at _____,
_____, Indiana, consent to the disclosure of the
following information to _____, the investigator of poor relief for
_____ Township _____ County, Indiana:

Information that will verify my:

1. Countable income.
2. Countable assets.
3. Wasted resources.
4. Relatives capable of providing assistance.
5. Past or present employment.
6. Pending claims or causes of action.
7. A medical condition if relevant to work or workfare requirements.
8. Any other information required by law.

This information may be used only in connection with:

- (1) my application of poor relief from _____ Township _____ County, IN.
- (2) my application for public assistance from the Division of Family and Children county offices and the Office of Medicaid Policy and Planning.
- (3) others (if any) _____

Signature of Applicant

Signature of other Adult

Signature of other Adult

Date Signed

Date Signed

Date Signed

This consent form expires 180 days after the date of signing.

ACKNOWLEDGMENT AND PLEDGE OF CONFIDENTIALITY BY THE TOWNSHIP

The undersigned township trustee or employee acknowledges that he/she may, in the course of employment, have access to certain personal information and that such information is to be treated as confidential, and is to be released and exchanged only with agencies related to the undersigned employment by the township in reviewing and investigating this application or as otherwise provided by law.

Trustee or Employee

Date Signed

(THIS PAGE FOR TOWNSHIP USE ONLY)

WORK ORDER:

Given _____ Amount _____ Completed _____

STATISTICAL SUMMARY OF THIS APPLICATION

Date	# Recipients Rec'v. Benefit	Utility \$ Benefits	Housing \$ Benefits	Food \$ Benefits	Health Care \$ Benefits	Other	Total \$ Benefits

S A M P L E

Training Program Referral	Referrals	Workfare Hours	Time Spent on Application

CASE RECORD OF INVESTIGATION

Name _____ Case No. _____
(Last) (First) (Middle)

Action taken or to be taken on your request(s) is as follows:

COMMENTS: _____

COMMENTS: _____

COMMENTS: _____

Township Trustee's Signature

APPEAL RIGHTS AND PROCEDURE

1. The township trustee shall act on your application within seventy-two (72) hours. (Excluding weekends and the State's legal holidays listed in IC 1-1-9) in accordance with IC 12-20-6-7.
2. If you disagree with the action taken on your case, you have a right to appeal to the board of county commissioners. Your request for an appeal should be in writing or orally as may be required by the board of commissioners. The appeal must be made within fifteen (15) days from the date the township trustee denies assistance, if the applicant has been informed of his right to appeal and the procedure for such appeal.
3. The hearing on your appeal may be conducted by the board of county commissioners or by a hearing officer appointed by that board within ten (10) working days after your appeal is received. In hearing the appeal, the board shall be governed by the uniform relief standards of eligibility and need established by the township trustee, to the extent the standards comply with existing law, for granting poor relief in the township.
4. At the hearing of your appeal you shall appear in person, may retain counsel, and may have persons speak in your behalf. This office is also entitled to be represented. However, you have the right to examine any evidence it introduces and to cross-examine its witnesses. You will be notified of the decision of the board within five (5) working days after the hearing.
5. If you wish to appeal the above action, fill out the appeal request form below.
6. Your or the township trustee may appeal a decision of the board of county commissioners to a circuit or superior court in the county. In hearing an appeal, the court shall be governed by uniform relief standards of eligibility and need established by the township trustee for granting poor relief in the township. If legally sufficient standards have not been established, the court shall be guided by the circumstances of the case.

APPEAL REQUEST - POOR RELIEF ACTION

_____ County Board of Commissioners Date: _____

(Address)

You are hereby notified of an appeal to the action by the Township Trustee, _____
_____, Township, _____ County, Indiana, on the
poor relief case of the undersigned, and a hearing is requested for the following reason(s): _____

I certify that the above statements are true and correct to the best of my knowledge and belief.

_____ Name

_____ Street Name and Number or R.R.

_____ Telephone

_____, IN _____
City or Town Zip Code

APPLICATION FOR ADDITIONAL OR CONTINUING TOWNSHIP ASSISTANCE

*Please do not
write in this
column.*

DATE: _____
 NAME: _____ PHONE: _____
 ADDRESS: _____

CASE NO.

Number of persons living at your address: _____
 Since your application with the trustee's office dated _____ has your income, resources or
 household size changed? YES _____ NO _____
 Are you or anyone else in the household working? YES _____ NO _____
 Are you or any member of your household under a doctor's care? YES _____ NO _____
 Have you/they applied for disability? YES _____ NO _____
 If YES, what is the status of the case? _____

SINCE THE DATE OF YOUR MOST RECENT APPLICATION:

Have you applied for AFDC? YES NO If receiving, give amount: _____
 Have you applied for Food Stamps? YES NO If receiving, give amount: _____
 Have you applied for Unemployment? YES NO If receiving, give amount: _____
 Have you applied for Energy Assistance? YES NO If receiving, give amount: _____
 Have you applied for / received assistance from any other source? YES NO If YES, explain: _____

What has been the household's: Total Income: \$ _____ Total Expenses: \$ _____

TODAY I AM REQUESTING ASSISTANCE WITH THE FOLLOWING:	AMOUNT (\$) REQUESTED	ACTION
SAMPLE		

INCOME AND EXPENSES

INCOME is any source of benefit to you, or any number of your household, whether money or payment assistance. This includes: work income, AFDC, housing assistance, odd job money, sick pay, relative or church assistance, EAP/Project Safe payments, Worker's Compensation, Social Security benefits, unemployment, child support, vacation pay, tax returns, bartered goods, etc.

EXPENSE is any bill you have already paid or anything on which you used the above income.

LIST ALL MONEY, INCOME, BENEFITS RECEIVED BY ANYONE IN YOUR HOUSEHOLD IN THE PAST THIRTY (30) DAYS:	AMOUNT (\$) RECEIVED	VERIFIED AMOUNT
<i>Date Received:</i> _____ <i>Received from:</i> _____ <i>Received for:</i> _____		

(OVER)

LIST ALL PURCHASES, EXPENSES, OR BILLS PAID BY YOU OR MEMBERS OF YOUR HOUSEHOLD IN THE PAST THIRTY (30) DAYS:*Please do not write in this column.*

<i>Paid for:</i>	<i>Date Paid:</i>	<i>Paid to:</i>	AMOUNT (\$) PAID OUT	ALLOWED/ VERIFIED
rent/mortgage				
electric service				
gas service				
water service				
sewer service				
phone payment				
food purchased				
babysitting/childcare				
transportation costs				
medical expenses				
insurance payment (state type)				
household items (specify)				
loans/charge payments				
other monthly cost (specify)				
cable television				
other (specify)				
other (specify)				
Expenses OWED (not paid) at this time:				
rent/mortgage amount:				
utilities (type and amount owed):				
other bills (specify type and amount owed):				

AFFIDAVIT

I affirm under the penalties of perjury that the information I have given on this application is true and correct to the best of my knowledge and belief in every respect as to myself and members of my family and household and has not changed since my last request for assistance other than what has been stated on this form; and that I have not withheld any information on matters bearing upon the eligibility and need for relief from myself and members of my family and household, and that I and the members of my family and household have no other means of support than those stated in this application. I also certify I have not been convicted under IC 35-43-5-7 (Welfare Fraud) and am eligible to receive poor relief assistance.

Applicant Signature _____ Date _____

Other Adult in Household _____ Date _____

Other Adult Signature _____ Date _____

Time of Day: _____ : _____ A.M./P.M.

OFFICE USE ONLY

TOTAL INCOME \$ _____ ALLOWED EXPENSES \$ _____ SURPLUS/DEFICIT \$ _____

Investigator Notes: _____

Investigator Signature: _____

OVERSEER OF THE POOR
PURCHASE ORDER FOR MEDICAL AID
TRUSTEE'S OFFICE

Purchase Order No. _____

Township, _____ County, Indiana. _____

TO _____

PLEASE SUPPLY _____ CASE NO. _____

Address _____

WITH THE FOLLOWING SERVICES

Office Call _____ \$ _____ Hospitalization (itemize fully) _____

House Call _____ \$ _____

_____ \$ _____ \$ _____

(Calls include all usual and ordinary medicines)

Unusual Medicines (itemize fully as to quantity, price, kind and necessity, Limited to U.S.P. and N.F.) _____ Surgery (describe fully) _____

_____ \$ _____

_____ \$ _____ Other Medical Services _____

Mileage, not over _____ miles, _____ \$ _____

(one way only outside city limits) _____ \$ _____

Tooth extraction, child's _____ Teeth \$ _____ O.B. Case, including all prenatal and

Tooth extraction, adult's _____ Teeth \$ _____ postnatal care \$ _____

_____ \$ _____ TOTAL AMOUNT OF THIS ORDER \$ _____

Statement of Patient as to illness _____

Disbursing Clerk _____ Authorized by _____ Township Trustee

INSTRUCTIONS: This form to be made out in triplicate; original to doctor or vendor, duplicate filed alphabetically in relief office, triplicate remaining in book in numerical order. Use indelible pencil or ink. Do not use check marks. Write out number of services authorized in words (as "one").

Wherever possible, at the time the purchase order is written, the total amount of the order must be inserted in the space provided for the same.

Purchase orders are valid only for the month in which they are written. Thus, an order given on the 20th day of the month would be void after the last day of that month insofar as permitting the recipient thereafter to obtain relief. Obtain new purchase order from Trustee if necessary in order to carry out this requirement.

All poor relief claims rendered, etc., will be on a calendar month basis. Claims must be rendered on the basis of the last past calendar month and for no other period.

Doctors or vendors are required to return their copies of poor relief purchase orders at the time they file their monthly claims. Such monthly claims must show the purchase order number for each number for each charge billed the Trustee's office. A separate claim must be filed for each township.

A report blank containing both the signature of the patient and the doctor or vendor must be submitted with the claim for each office call, house call or other service for which a charge is rendered. Any charge shall not exceed the amount prescribed in the fee schedule in force.

OVERSEER OF THE POOR
GENERAL PURCHASE ORDER FOR POOR RELIEF
TOWNSHIP TRUSTEE'S OFFICE

No. _____

Ind., _____ County, _____ Township, _____

Date of Order _____

To _____

Please Supply _____ Case No. _____

WITH THE FOLLOWING:

Food ----- \$ _____ --- \$ _____ --- \$ _____

Fuel --- ----- \$ _____ --- \$ _____ --- \$ _____

Clothing ----- \$ _____ --- \$ _____ --- \$ _____

DISBURSING CLERK _____ Total Amount of This Order \$ _____

Authorized By _____ Township Trustee

CUSTOMER'S RECEIPT

I have received in full the items authorized by this order.

VENDOR'S STATEMENT

I have furnished the customer with the full amount of supplies or other items
authorized by this order.

Signed _____

Signed _____

(See the reverse side for instructions relative to filing this order and for detailed list of supplies, etc., to be furnished customer)

Required by Governor's Commission on Unemployment Relief

[illegible]

	Quantity	Size	Description	Unit Price	Total Amount
SAMPLE					
TOTAL					

[illegible][illegible][illegible]

	Quantity	Size	Description	Unit Price	Total Amount
SAMPLE					
TOTAL					

[illegible]

REPORT ON MEDICAL AID RENDERED

On Purchase Order No. _____, _____, _____, _____		Township _____	County, Indiana _____
Name of Patient _____		Date of Service _____	Case Number _____
Address _____			
Diagnosis _____			
Office Call _____	\$ _____	Hospitalization (itemize fully) _____	
House Call _____	\$ _____		
	\$ _____		\$ _____
(Calls include all usual and ordinary medicines.)		Surgery (describe fully) _____	
Unusual Medicines, (itemized fully as to quantity, price, kind and necessity. Limited to U. S. P. and N. F. _____)			\$ _____
Mileage, _____ miles (one way only outside city limits) _____		Other Medical Services _____	\$ _____
Tooth extraction, Child's _____	Teeth \$ _____	O. B. Case, including all prenatal and post-natal care _____	\$ _____
Tooth extraction Adult's _____	Teeth \$ _____		
	\$ _____		
PATIENT'S RECEIPT		DOCTOR'S OR VENDOR'S STATEMENT	
I have received in full the items and services listed above and authorized by this order.		I have furnished the customer with the full amount of services, or other items listed above and authorized by this order.	
Signed _____		Signed _____	
(Patient or head of household)			

INSTRUCTIONS

Signature of patient or head of household must be obtained on properly itemized report blank on both emergency and other services rendered. All payments for emergency calls and tentative authorizations are contingent upon results of relief investigation by visitor.

This form to be made out in triplicate. Original submitted with purchase order and claim, duplicate to be retained by person rendering service.

Do not charge for any miles except those actually and necessarily traveled outside of the city limits for the purpose of the call. Calls to be grouped whenever possible in trips. Only one mileage charge allowed when more than one call made on same trip or in same household. Mileage one way only allowed.

When purchase order authorizes more than one call or service, separate report blanks must be submitted for each and every call and service rendered. This report can cover only one charge. Every charge must be specifically authorized by purchase order. Amount authorized by purchase order cannot be exceeded.

EMERGENCY SERVICE

Generally a township is not under obligation to pay a claim for medical or surgical aid to the poor unless such services have been ordered or contracted for by the township trustee. However, in case of extreme emergency where delay for the purpose of communicating with the trustee might result in loss of life or other serious consequences to the patient, the physician or surgeon rendering the relief necessary would be entitled to payment therefor from the township poor fund without having been ordered by the trustee to perform such services. (See Newcomer V. Jefferson Twp. 181 Ind. 1) Legal Guide to Public Officials of Indiana, published by State Board of Accounts 1932.

It is contemplated by the law that the overseer of the poor "****shall, in cases of necessity, promptly provide medical and surgical attendance for all of the poor in his township who are not provided for in public institutions****." Burns 1935 Supplement 52-148.

Required by Governor's Commission on Unemployment Relief

Claim No. _____ Warrant No. _____

IN FAVOR OF

**MILEAGE
ON ACCOUNT OF POOR RELIEF**

_____, Township

Certified by Trustee, \$

Paid from County Poor Funds, \$

Appropriation No. _____

I have examined the within claim and hereby
certify as follows:

That it is in proper form.

That it is duly authenticated as required by law.

That it is based upon statutory authority.

correct

That it is apparently

incorrect

in the

sum of \$ _____ ,

Auditor

(BOTTOM OF PAGE)

_____ , _____ .

Trustee of _____ Township

and hereby certify the sum of \$ _____ is due claimant.

_____ and was in accordance with contract, except

I certify that the within is true and correct; that the supplies and materials therein itemized and for which charge is made were ordered by me and were necessary to the public business; that each and every item has been delivered at prices mentioned,

TOWNSHIP QUARTERLY POOR RELIEF REPORT OF ACTUAL AND
ESTIMATED RECEIPTS AND DISBURSEMENTS

_____ TOWNSHIP _____ COUNTY, INDIANA

Pursuant to IC 12-20-21-5 the following report is submitted showing the condition of the poor relief funds of the above named township for the period ending March 31, ____, June 30, ____, September 30, ____, or December 31, ____.

<u>For Present Calendar Year</u>	<u>Actual Year to Date</u>	<u>Actual and Estimated to December 31</u>
1. Cash Balance January 1	\$ _____	\$ _____
2. Receipts (actual and estimated):		
(a) Receipts from temporary loans	_____	_____
(b) Receipts from advances by county	_____	_____
(c) All other cash received	_____	_____
(d) Estimated tax collections (including vehicle excise, Financial Institution and COIT taxes)	XXXXXXXXXX	_____
(e) Other anticipated receipts to December 31 (refunds, reimbursements, sale of bonds, etc.)	XXXXXXXXXX	_____
(f) Total actual and estimated receipts (Add 2a-2e)	_____	_____
3. Total balance and receipts (Line 1 plus Line 2f)	_____	_____
4. Disbursements (actual and estimated):		
(a) Direct relief and administration	_____	_____
(b) Unpaid purchase orders, PR-2 and PR-3	_____	_____
(c) Estimated poor relief expense and bonds and interest payable to December 31	XXXXXXXXXX	_____
(d) Repayment of temporary loans, line 2a principal \$ _____ interest \$ _____	_____	_____
(e) Repayment of prior year advances by county	_____	_____
(f) Total actual and estimated disbursements (Add 4a-4e)	_____	_____
5. Actual or estimated balance or overdraft. (Line 3 less Line 4f)	=====	=====
If overdraft:		
(1) the township board shall appeal to borrow money under IC 12-20-24;		
(2) if the township board does not appeal or if an appeal fails, the board of commissioners may borrow money or otherwise provide the money. (IC 12-20-20-2)		

NOTE: The term "advances" means funds to be repaid from next year's poor relief loan fund tax levy, as distinguished from temporary loans required to be repaid in the current year.

Dated: _____

Signature of Township Trustee

PREPARE IN TRIPLICATE: One copy to Chairman of Township Board; one copy to County Auditor; one copy for files of Township Trustee.

___ TOWNSHIP DIVISION

[illegible]

<div style="border-bottom: 1px solid black; padding-bottom: 5px;">Township Docket Fees \$ _____</div> <div style="border-bottom: 1px solid black; padding-bottom: 5px;">Service of Process: Registered or Certified Mail. _____</div> <div style="border-bottom: 1px solid black; padding-bottom: 5px;">Personal Service. _____</div> <div style="border-bottom: 1px solid black; padding-bottom: 5px;">Appeal Bonds _____</div> <div style="border-bottom: 1px solid black; padding-bottom: 5px;">Redocket Fees. _____</div> <div style="border-bottom: 1px solid black; padding-bottom: 5px;">Witness Fee. _____</div> <div style="border-bottom: 1px solid black; padding-bottom: 5px;">Trust Funds. _____</div> <div style="border-bottom: 1px solid black; padding-bottom: 5px;">. _____</div> <div style="border-bottom: 1px solid black; padding-bottom: 5px;">. _____</div> <div style="border-bottom: 1px solid black; padding-bottom: 5px;">. _____</div> <div style="border-bottom: 1px solid black; padding-bottom: 5px;">TOTAL \$ _____</div>	<div style="text-align: center; border-bottom: 1px solid black; padding-bottom: 10px;">OFFICIAL RECEIPT - Marion County Small Claims Court Township Division</div> <div style="border-bottom: 1px solid black; padding-bottom: 5px;">No. _____</div> <div style="border: 1px solid black; padding: 5px; margin: 10px 0;"><table border="1" style="width: 100%; border-collapse: collapse;"><tr><th colspan="6">Payment Type and Amount</th></tr><tr><td style="width: 16.6%; text-align: center;">Cash Amount</td><td style="width: 16.6%; text-align: center;">Check/Draft Amount</td><td style="width: 16.6%; text-align: center;">MO Amount</td><td style="width: 16.6%; text-align: center;">Credit Card/ Bank Card Amount</td><td style="width: 16.6%; text-align: center;">EFT Amount</td><td style="width: 16.6%; text-align: center;">Other</td></tr><tr><td style="height: 40px;"></td><td></td><td></td><td></td><td></td><td></td></tr></table></div> <div style="border-bottom: 1px solid black; padding-bottom: 5px;">Cause No. _____</div> <div style="border-bottom: 1px solid black; padding-bottom: 5px; text-align: center;">vs.</div> <div style="border-bottom: 1px solid black; padding-bottom: 5px;">Received of _____</div> <div style="border-bottom: 1px solid black; padding-bottom: 5px;">the sum of _____ Dollars \$ _____</div> <div style="border-bottom: 1px solid black; padding-bottom: 5px;">Docket No. _____ Page _____</div> <div style="text-align: right; padding-right: 50px;">Judge _____</div>	Payment Type and Amount						Cash Amount	Check/Draft Amount	MO Amount	Credit Card/ Bank Card Amount	EFT Amount	Other						
Payment Type and Amount																			
Cash Amount	Check/Draft Amount	MO Amount	Credit Card/ Bank Card Amount	EFT Amount	Other														

Township Docket Fees \$ _____ Service of Process: Registered or Certified Mail. _____ Personal Service. _____ Appeal Bonds _____ Redocket Fees. _____ Witness Fee. _____ Trust Funds. _____ _____ _____ _____ <div style="text-align: right;">TOTAL \$ _____</div>	OFFICIAL RECEIPT - Marion County Small Claims Court Township Division <div style="display: flex; justify-content: space-between;"> <div>_____</div> <div>No. _____</div> </div> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <tr> <th colspan="6">Payment Type and Amount</th></tr> <tr> <th style="width: 16.6%;">Cash Amount</th><th style="width: 16.6%;">Check/Draft Amount</th><th style="width: 16.6%;">MO Amount</th><th style="width: 16.6%;">Credit Card/ Bank Card Amount</th><th style="width: 16.6%;">EFT Amount</th><th style="width: 16.6%;">Other</th></tr> <tr> <td style="height: 40px;"> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </table> <div style="margin-top: 10px;"> Cause No. _____ _____ vs. _____ Received of _____ the sum of _____ Dollars \$ _____ </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div>Docket No. _____ Page _____</div> <div>Judge _____</div> </div>	Payment Type and Amount						Cash Amount	Check/Draft Amount	MO Amount	Credit Card/ Bank Card Amount	EFT Amount	Other						
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Township Docket Fees \$ _____	OFFICIAL RECEIPT - Marion County Small Claims Court Township Division	
Service of Process: Registered or Certified Mail. _____	No. _____	
Personal Service. _____		
Appeal Bonds _____		
Redocket Fees. _____		
Witness Fee. _____		
Trust Funds. _____		
. _____		
. _____		
TOTAL \$ _____		

Payment Type and Amount					
Cash Amount	Check/Draft Amount	MO Amount	Credit Card/ Bank Card Amount	EFT Amount	Other

Cause No. _____

vs.

Received of _____

the sum of _____ Dollars \$ _____

Docket No. _____ Page _____ Judge _____

Prescribed by State Board of Accounts

Township Form No. 83M (Revised 1987)

MARION COUNTY SMALL CLAIMS COURT
_____ TOWNSHIP DIVISION

No. _____

_____, _____ Pay to the
Order of _____ \$ _____

Dollars

For

100

_____ Docket No. _____ Page _____ Cause No. _____

Judge

Prescribed by State Board of Accounts

Township Form No. 83M (Revised 1987)

MARION COUNTY SMALL CLAIMS COURT
_____ TOWNSHIP DIVISION

No. _____

_____, _____ Pay to the
Order of _____ \$ _____

Dollars

For

100

_____ Docket No. _____ Page _____ Cause No. _____

Judge

Prescribed by State Board of Accounts

Township Form No. 83M (Revised 1987)

MARION COUNTY SMALL CLAIMS COURT
_____ TOWNSHIP DIVISION

No. _____

_____, _____ Pay to the
Order of _____ \$ _____

Dollars

For

100

_____ Docket No. _____ Page _____ Cause No. _____

Judge

ORIGINAL

Prescribed by State Board of Accounts

Township Form No. 84M (Revised 1997)

MARION COUNTY SMALL CLAIMS COURT
TOWNSHIP DIVISION

No. _____

Payment Type and Amount					
Cash Amount	Check/Draft Amount	MO Amount	Credit Card/ Bank Card Amount	EFT Amount	Other

_____, _____ Pay to the
Order of _____ \$ __________
Dollars

For _____

Docket No. _____ Page _____ Cause No. _____**DUPLICATE**

Prescribed by State Board of Accounts

Township Form No. 84M (Revised 1997)

OFFICIAL RECEIPT

MARION COUNTY SMALL CLAIMS COURT
TOWNSHIP DIVISION

No. _____

Payment Type and Amount					
Cash Amount	Check/Draft Amount	MO Amount	Credit Card/ Bank Card Amount	EFT Amount	Other

_____, _____ PAID TO _____ \$ _____

Dollars

RECEIVED FROM _____

Docket No. _____ Page _____ Cause No. _____**TRIPLICATE**

Prescribed by State Board of Accounts

Township Form No. 84M (Revised 1997)

TRUST FUNDS

MARION COUNTY SMALL CLAIMS COURT
TOWNSHIP DIVISION

No. _____

Payment Type and Amount					
Cash Amount	Check/Draft Amount	MO Amount	Credit Card/ Bank Card Amount	EFT Amount	Other

_____, _____ PAID TO _____ \$ _____

Dollars

RECEIVED FROM _____

Docket No. _____ Page _____ Cause No. _____If this is last Receipt - Check for day, enter day's
total here and in Cash Book